CLINICAL NOTES, CASE REPORTS AND NEW INSTRUMENTS

XANTHOMA DIABETICORUM

CASE REPORT

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XANTHOMA diabeticorum is an exceedingly rare skin condition, first described by Addison and Gull in 1851. The great majority of the reported cases since that time have occurred in glycosuric individuals. The disease does occasionally occur in individuals in whom glycosuria is absent, however. Ninety per cent of all reported cases have appeared in males between the ages of 21 and 57 years. Politzer, however, reported the condition in a boy of 17.

The lesions usually occur over the buttocks, knees, and elbows; as rather thick, hard, yellowish papules and plaques, varying in size from a small shot to that of a pea or larger, superimposed upon a reddish base. These lesions may be tender or even painful, and the sensations of burning or itching may be absent or very marked. Resolution usually occurs spontaneously without leaving any change in the skin texture, and takes place in many cases without any relation to the amount of sugar present in the urine.

Goldstein and Harris reported a case in 1927 in which three types of resolution occurred simultaneously, with little or no reference to the general condition of the patient. Some of the lesions disappeared, leaving no change in the skin structure; some left marked pigmentation; and some marked and destructive scarring.

Anatomically the xanthoma nodules are very similar to those of xanthoma multiplex, except that there is much more evidence of an active and inflammatory process and less of connective tissue increase.

CASE REPORT

On October 6, 1926, Q. K. T., a Chinese butcher, weighing 230 pounds, presented himself, complaining of having gradually developed a number of raised, hard nodules and papules in his skin during the preceding year. These had not been red nor had they caused him any discomfort; but he had not liked their appearance and had become alarmed because they were becoming more numerous and because the individual lesions had gradually enlarged.

He was married and had two children, one of whom, a girl of three years, was suffering from infantile eczema. The family history was otherwise negative.

He had always been well and strong, having had no physical ills other than moderately frequent attacks of headache. He was a large eater and drank rather large quantities of tea. Was very fond of rice and sugar, never stinting himself in the use of either. He had not noticed any polyuria.

Examination of the skin showed some eighteen or twenty ocher-colored papules scattered over his arms, palms, thighs, soles, and trunk, without any apparent predilection for any one part.

Several of the diseased areas were from one-half to three-fourths inches in diameter, the papules being arranged in distinct circles about a clear, slightly bluish center. None of the papules, even those appearing singly, showed any redness about the base. They were all very hard and shot-like, not tender or painful, and were freely movable upon the subcutaneous tissues. The isolated papules varied in size from that of a small shot to nearly one-fourth inch in diameter.

The urine had a specific gravity of 1030 and gave a very marked reaction for sugar with the Fehling test.

He was advised to give up the use of sugar and rice and to substitute saccharin and diabetic bread. In addition to the diet regulation he was given 1 cc. of Iletin (Lilly) hypodermatically, three times a week.

At the end of six weeks all of the papules and circles had disappeared, only a light pigmentation and a slight atrophy of the skin remaining at the site of each lesion. This pigmentation and atrophy has remained to the present date.

The sugar in the urine disappeared within one week after treatment was instituted, and by the end of the sixth week he had lost some thirty-five or forty pounds in weight. At that time he stated that he felt better than he had been for a long time and that he had no more headaches.

Since the disappearance of the lesions he has reported only at long intervals and says that he has gradually resumed the eating of rice and bread in small amounts and that he has had no recurrence of his headaches. No glycosuria has returned, except at times when he overindulges in carbohydrates. No new skin lesions have appeared during the past year.

COMMENT

The striking features of this case were:

1. The absence of redness at the base of the lesions;
2. The occurrence of lesions on the palms and soles;
3. The occurrence of circles of papules about a bluish center; and
4. The persistence of slight pigmentation with a slightly atrophic condition at the site of former lesions.

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ACUTE ANGIONEUROTIC EDEMA OF THE LARYNX

CASE REPORT

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ACUTE angioneurotic edema of the larynx is a rare but very dangerous complication, resulting many times in the death of the patient. No way of foreseeing or preventing such edema is known. The literature is very scarce and the subject is known very little to the general practitioner or to the specialist. Further data are greatly needed. The writer therefore believes it worth while to report a case which occurred recently in his practice and to discuss, briefly, the literature.

CLINICAL DESCRIPTION

The best clinical definition of this affection can be expressed by the words of C. Theisen.[1] "The writer has always believed that the type of laryngeal edema is frequently neurotic when it comes apparently out of a 'clear sky' and develops so rapidly that alarming difficulty in breathing comes on almost at once, without a definite preliminary infection somewhere in the throat, as an etiologic factor. There is rarely any temperature. The patient is perfectly well and in fifteen or twenty minutes is struggling for air. There have been a number of cases of sudden death in this form of neurotic or angioneurotic edema reported."

H. Fisher of Breslau,[2] a physician to the courts, demonstrated twenty original specimens of the

larynx collected by himself, where sudden death due to edema of the glottis had occurred, and discussed the medico-legal aspect of this disease, because a suspicion of poisoning or trauma inflicted by another person in these extremely sudden deaths is liable to follow.

ETIOLOGY AND REVIEW OF CASE REPORTS

The writer has analyzed the available case reports to determine to what conditions this complication has been ascribed.

Staffleri [3] considers inherited nervous conditions an important etiological factor, a result of exaggerated excitability of certain nerves controlling the circulation of lymph. The cause of the nervous hyperexcitability, according to this author, is defective endocrine function with thyroid insufficiency predominating. Osler points to the same cause and reports a family in which, in the course of five generations, nineteen members out of a total of thirty-nine had angioneurotic edema, two dying of edema of the larynx. He states that edema may be induced by some toxin in the intestinal tract, and in a certain percentage of cases the larynx is the first part to be involved.

Gastric disturbances are cited as the etiologic cause by some authors. F. Simon reported a case of edema of the larynx which developed after the patient ate fish. V. Schrotter [4] mentions a case in which a patient with a chronic intestinal catarrh likewise developed edema of the larynx and died.

Edema of the larynx has followed tonsillectomy. D. Husik [5] reports a case in which tonsillectomy under general anesthesia in the University Hospital, Philadelphia, was followed by a slowly progressive edema toward the evening of the next day. After midnight a tracheotomy was necessitated. The patient recovered gradually. When edema develops rapidly the patient presents signs of a general collapse in a few minutes. Even when a correct diagnosis is made there is not always time to perform a tracheotomy. In the *Kentucky Medical Journal* Tuley reports a case in which death occurred within fifteen minutes, while preparations for a tracheotomy were being made. C. Theisen suggests that some cases of sudden death may have been due to localized cerebral edemas involving the respiratory or cardiac centers.

Three cases reported by F. Kennedy [6] of brain swelling in angioneurotic edema support this opinion. Protein sensitization test in one proved the patient to be susceptible to milk. P. Bassoe, discussing Drysdale's [7] paper about acute edemas, reported a case in which a brain tumor was suspected and decompressive operation performed. The subsequent history of the case, however, proved that the condition was angioneurotic edema, many attacks having occurred over a period of twelve years on different parts of the body. Finally some badly abscessed teeth were removed and, according to G. Hall, the patient recovered completely. Bassoe admitted that this was a case in which apparently the brain had been first affected.

While some authors think that food protein sensitization is the etiologic basis for certain cases, the symptoms being interpreted as anaphylactic disturbance, others believe that the outstanding cause is sensitization to bacterial rather than to food proteins, as a result of focal infection. H. Barber [8] has observed cases in which the edema completely subsided after extraction of septic roots, treatment of pyorrhea, eradication of sinus infection, and enucleation of tonsils. Oberndorf [9] reported a case of angioneurotic edema which entirely disappeared after an acutely inflamed appendix had been removed.

In some cases the etiology of the edema of the larynx is entirely obscure. For instance, W. Freudenthal[2] reports three cases of sudden edema of the larynx with one death in women after childbirth. Previous examination had not revealed any abnormality in these patients.

Rethi reports a case in which angioneurotic edema of the larynx occurred twice during menstruation.

Malnutrition apparently is sometimes a causative factor in edemas, as shown by His, of Berlin, who reports on cases studied by him during the last war; these cases improved when fat was added to the diet.

CASE REPORT

Mr. B., 38 years old, came to my office April 26, 1927, and gave a history of having been in the Pasadena Hospital for twenty-five days, where a diagnosis of ulcer of duodenum, chronic appendicitis, chronic tonsillitis, chronic mitral endocarditis (well compensated) and gastric hyperacidity had been made and a tonsillectomy advised.

The operation was performed next day at my office under local anesthesia, the patient being under my personal care for about an hour and a half following the operation and feeling well. Then he was left under the care of a nurse, and was all right for another three-quarters of an hour, when he complained of not feeling well. The nurse took his pulse—it was 80. The patient was made comfortable in bed, gave a sign that he was better, but in a few minutes complained again. He was asked if he was nervous, and instructed, as is usual after tonsillectomies, to write the answer. He wrote: "I am not nervous, but can't breathe. O my . . ." and fainted. His head was bent down, the feet lifted, 1 cc. of adrenalin chlor. 1:1000 injected, and a physician called who arrived in two or three minutes. He found the patient with a very weak pulse and unconscious, again injected 1 cc. of adrenalin and started artificial respiration. At this time I returned and, interpreting ex consilio the condition of the patient as a collapse, adrenalin was injected into the heart and artificial respiration continued. A pulmotor was sent for and arrived in ten or twelve minutes. After the pulmotor was in action about fifteen minutes I decided to examine the patient's throat to determine if there were any bleeding from the tonsils. I opened the patient's mouth, removed the air tube inserted by the fireman and the packing from the fossae, and found no bleeding. The pulmotor was again started and artificial respiration kept up for a certain time, but all efforts to revive the patient failed.

Autopsy findings (Dr. A. F. Wagner): Stomach, intestines, kidneys, heart—negative. Lungs: congestion. Spleen enlarged. Thymus gland enlarged, not subinvoluted. Larynx: edema of the epiglottis and of the larynx upon and about the vocal cords. Not any sign of inflammation in the larynx nor any blood in the stomach.

Verdict of coroner's jury as to the cause of death: "Strangulation following edema of the epiglottis and of the larynx, following operation for removal of tonsils performed by Dr. Benjamin Katz. We believe

that Dr. Benjamin Katz rendered medical aid to the best of his ability."

From an etiologic point of view the writer's case closely resembles Schrotter's and Husik's cases, namely, the patient having a chronic catarrh of the intestines associated with an enlarged thymus and spleen (status lymphaticus) developed about two hours after tonsillectomy, an acute fatal edema of the larynx.

PATHOLOGY

Hajek experimentally demonstrated by injection of liquids into the larynx of a cadaver that edema spreads according to certain laws. The great vascularity of the larynx, together with the fact that the blood vessels of the mucous membrane are practically unsupported, permits rapid congestion, and there is a leakage into the perivascular tissue. The exuded serum fills the intercellular spaces and lymph channels, giving them an appearance of a semitransparent swelling. There is no inflammation present. According to several case reports proven clinically and microscopically, the edema of the larynx can be accompanied by simultaneous edema of the brain, probably involving the respiratory and cardiac centers.

DIAGNOSIS

Presence of a semitransparent swelling in the larynx without any inflammatory condition, accompanied by signs of difficulty in breathing, makes the diagnosis possible when the progress of the edema is slow. In rapidly developing cases of edema the symptoms of general collapse prevail, the edema being detected only after death.

TREATMENT

C. Theisen, who had a few cases of edema of the larynx under his observation, recommends a cold spray of adrenalin 1 : 5000 and an ice coil around the neck. When difficulty in breathing develops, incisions with the Schrotter-guarded laryngeal knife or a tracheotomy is indicated. It is worth while to mention that in rapidly progressing edema of the larynx the patient may die before a tracheotomy can be performed, or even when a tracheotomy has been done, if edema involves the brain.

SUMMARY

Acute angioneurotic edema of the larynx is a rare but very dangerous complication, which, in our present knowledge, can neither be foreseen nor prevented. Its etiology is obscure. In recorded cases inherited nervous conditions, gastric disturbances, focal infection, endocrine disorders, malnutrition, and anaphylactic disturbances have been noted. The treatment indicated often fails because of the rapidity of involvement or because of edema of the brain. The literature of the subject is very scanty. Therefore all cases should be reported in order that further data may be collected for study.

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A NEW GLASS DRAINAGE TUBE FOR SUPRAPUBIC PROSTATECTOMY

By L. Lore Riggin
Pasadena

Drawing, to scale, of a glass drainage tube for use in suprapubic prostatectomy cases. The drawing is self-explanatory.

Advantages claimed over the Freyer tube are:

1. By the two "arm" outflow, the patient may lie on either side without disturbing the drainage.

2. The two "arm" supports on the dressings, make a more comfortable dressing for the patient.

3. By the "through-and-through" opening of the large tube, obstructing clots may be attacked by alligator forceps and be removed.

4. Through this same avenue the catheter may be passed when doing the postoperative irrigations of the bladder.

5. Free exit of urine and irrigating solutions is possible without soiling the dressings, and without causing tension on the bladder walls, and without changing position of the patient.

6. Much easier postoperative care of the bladder with the least discomfort to the patient.

The large upper opening is kept closed with a rubber stopper when not used; each side "arm" has a length of soft rubber tubing attached, with a glass connection on the distal end for making connection with the tubing leading to the reservoir (connection being made with the dependent one).

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